Provider NPI:
Group NPI:
EIN:

Verification of Benefits Form

Obtain copy of front & back of insurance card card & copy of patient's driver license

Patient's Name:_____

Patient's Date of birth: _____

Home Address : Street_____ **City** _____ **State**_____ **Zip**_____

Name of Insurance: _____ **Insurance ID Number:** _____

Applicable ICD 10 codes:

_____

Date: _____ Time: _____ Representative:_____

Policy type: PPO   HMO   POS   Other _____

Benefit period: From _____   To _____

Is this a **FULLY** funded plan?   Yes   No   Is this a **SELF**-funded plan?   Yes   No

Is this policy a **grandfathered** plan not needing to adhere the **ACA**?   Yes   No

Does this policy have Nutrition Counseling/Medical Nutrition Therapy Benefits?   Yes   No

Which **CPT codes** are covered on this policy?   97802   97803   97804   S9470   99401-99404

Are **BOTH** preventative nutrition services covered under **Health Care Reform** AND medical benefits covered?   Yes   No

Does this plan cover **telehealth** services?   Yes   No
Is there a **co-pay** for telehealth services   Yes   No   Amount $_____

Does this plan require an **MD referral**   Yes   No

Does this plan require **prior authorization** for nutrition services   Yes   No   Comments

Does this plan require the dietitian submit **medical documentation**   Yes   No
Fax # to send notes _____

Coverage for PREVENTATIVE MNT services includes: Comments:
Number of visits _____
Limit on number of units ____
Deductible applies $_____
Co-pay applies $_____
Co-insurance applies _____ %

Coverage for MEDICAL MNT services includes: Comments:
ICD 10 codes to verify _____
Number of visits _____
Limit on number of units _____
Deductible applies $_____
Co-pay applies $_____
Co-insurance applies _____ %

Reference # for this call _____